Los Angeles County Department of Health Service Emergency Medical Services Agency Sexual Assault Response Team Center

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| Name of Ho | spital: | | |
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| Address: | | | |
| Telephone:_ | | | |
| Please subn | nit a copy of: | | |
| • | State Department of Health Services License (DHS) | | |
| • | Accreditation from Joint Commission of Accreditation of Healthcare Organizations (JCAHO) | | |
| • | Permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5, California Code of Regulations | | |
| ADMINISTR | ATION/COORDINATION | | |
| Chief Execu | tive Officer: | Telephone | |
| SART Program Director: | | Telephone | |
| SART Medical Director: | | Telephone | |
| SART Center Coordinator: | | Telephone | |

MEDICAL ADVISOR Name: _____ Board Certified in: Board Certification Expiration Date: Board Certification Number: If not Board Certified, eligible to take Board Certification in _____ Please send a copy of the Medical Advisor's Certification. SART CENTER PROGRAM DIRECTOR Name Nursing License Number_____ Expiration date_____ Completion Date of Sexual Assault Examiner Course SART CENTER COORDINATOR Name Nursing License Number Expiration date Completion Date of Sexual Assault Examiner Course ADVOCATE Name of the Rape Crisis Center: Crisis Center Director:

Please submit:

- 1. Documentation of OCJP training
- A sample page of the log book and staff/volunteer schedule or other documentation indicating 24- hour availability. At the time of the survey, have available the log book and staff/ volunteer schedule or other documentation indicating 24 hour availability for the past 6 months.

PERSONNEL-Sexual Assault Nurse Examiner/Sexual Assault Forensic Examiner

| Name | MD/RN License Expiration Date | Completion date of SART examiner course |
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